

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

09281

Reg. Dist. No. 265

1. PLACE OF DEATH:

County Somerset
 City or town Brimfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Somerset
 City or town Brimfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Charlet Virginia Barkley

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife John H. Barkley

7. Birth date of deceased (mo., day, yr.) Mar 1 1876 8. (c) If alive, give age _____ years

8. AGE: Years 70 Months 7 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Allen Md
 (Town, county, and state)

10. Usual occupation House Work

11. Industry or business _____

12. Name John H. Noble

13. Birthplace Allen Wisconsin

14. Maiden name Sarah E. Burke

15. Birthplace Mount Vernon Somerset

16. Informant Margaret Hughes Hainwright

Address Traskin Md 21215

17. Burial Date thereof Sept 4 - 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allen

Location Allen Md.

18. Funeral director Chas H Ward

Address Marion Md.

19. 9/3/46 C. E. Allen Jr.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 19 46 at 4 a. M

21. I CERTIFY that death occurred on the date above stated; that patient deceased from Aug 31 19 46 to Sept 2 19 46

and that I last saw him/her alive on Sept 2 19 46

Immediate cause of death Coronary occlusion

Due to Cardio-vascular renal disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Chas. P. Schwab

Address Brimfield Date signed Sept 2/46

RECEIVED

OCT 4 1946

BUREAU V S

ARTESIAN LEAD

RAG CONTAINER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age
of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09282

FILE No. I 07 SEP 16 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:

County Somerset
City or town Princess Anne Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sue Ann Buereton

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)

Dec. 8, 1854

8. AGE:

Years

Months

Days

If less than one day

92

91

—

—

hrs.

min.

9. Birthplace

Princess Anne Somerset Co.
(town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

46

R. A. Jones

Reg. d.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Somerset

City or town

Princess Anne Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 1

19

46 at 2:40 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h. alive on

19

Immediate cause of death

arteriosclerosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

[Signature]

M. D. or other

Address

[Signature]

Date signed

9/1/46

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SEP 7 1945
BUREAU V 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (442)

CERTIFICATE OF DEATH

09283 260
Reg. Dist. No.

1. PLACE OF DEATH:

County... Somerset
City or town... Revelle Neck
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Somerset
City or town... Revelle Neck Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Westover - post office
(If rural, give LOCATION)2. (a) If veteran, name war none

3. (a) FULL NAME

Honetta Boyman

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife William Boyman7. Birth date of deceased (mo., day, yr.) Feb 11, 1898 6. (c) If alive, give age 29 years8. AGE: Years 48 Months 13 Days 13 If less than one day hrs. min.9. Birthplace Shadyside Amherst Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Charles Carson13. Birthplace Shadyside Md.14. Maiden name Sadie Bullen15. Birthplace Shadyside Md.16. Informant Mr. Refellum BoymanWestover
Post Office Revelle Neck Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Sept 28, 1946
(month) (day) (year)Cemetery or crematory Princess Anne Md.Location Charles DASHWELL18. Funeral director Princess Anne Md.Address Sept 25 46(Date rec'd by registrar) 19 Princess Anne Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 19 46 at 8:10 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 19 46 to Sept 24 19 46
and that I last saw him alive on Sept 24 19 46Immediate cause of death Medicine
Disease

DURATION

2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank Matus MD

M. D. or other

Address Princess Anne Date signed 9/25/46

RECEIVED
SEP 27 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

09284

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Somerset

City or town Lonsfield
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Lonsfield
(If outside city or town limits, write RURAL and give nearest town)

Street No. Back Hill Rd
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Lyda E Bradshaw

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife Andrew J

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1882

8. AGE: Years Months Days If less than one day
64 4 23 hrs. min.

9. Birthplace Lonsfield
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

12. Name George E Walker

13. Birthplace Somerset Pa

14. Maiden name Sallie Carter

15. Birthplace MD

16. Informant Louis E Watson

Address Mariners Rd Lonsfield, MD

17. Burial Date thereof Sept 29, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bunny Ridge

Location Lonsfield

18. Funeral director Howard H. Hubbard

Address 386 Main St Lonsfield, MD

19. Sept 24 19 46 C E Collier
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 19 46, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19, 45 to Sept 26, 1946

and that I last saw her alive on Sept 1, 1946

Immediate cause of death myocarditis

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE S. M. Peyton M. D. or other

Address Crisfield, Md Date signed Sept 29, 1946

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 4 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17020

09285

CERTIFICATE OF DEATH

Reg. Diat. No. 260

1. PLACE OF DEATH:

County... Somerset
City or town... near Pocomoke
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Unknown County...

City or town...
(If outside city or town limits, write RURAL and give nearest town)Street No...
(If rural, give LOCATION)

2.(a) If veteran, name war... II

3. (a) FULL NAME

James Cooper

3. (b) Social Security Number

225-22-5356

4. Sex... Male 5. Color or race... Colored 6. (a) Single, married, widowed, or divorced... Unknown

6. (b) Name of husband or wife... Unknown

7. Birth date of deceased (mo., day, yr.)... 6. (c) If alive, give age... years

8. AGE: Years... 39 Months... Days... If less than one day... hrs. min.

9. Birthplace... Sarasota Florida
(Town, county, and state)

10. Usual occupation... Farm laborer

11. Industry or business

12. Name... unknown
13. Birthplace...

14. Maiden name... unknown
15. Birthplace...

16. Informant... Army Discharge
Address...

17. Burial... Date thereof... Sept 26, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... Mt Vernon
Location... Princess Anne, Md.

18. Funeral director... Charles Dashiell
Address... Princess Anne, Md.

19. Sept. 26, 1946 R.D. Johnson, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept 24, 1946, at 6(2) P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from... to... and that I last saw him alive on... 19...

Immediate cause of death... Crushed skull and other serious injuries

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Accident Date of 9/24/46

Where did injury occur? Route 13 Somerset, Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of injury Struck by truck Injured at work? No

23. SIGNATURE... Henry M. Raulford, M.D.

Address... Princess Anne M. D. or other

Date signed... 9/25/46

RECEIVED

SEP 27 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 117-2

CERTIFICATE OF DEATH

09286

Reg. Dist. No. 333

1. PLACE OF DEATH:

County SomersetCity or town Princess Anne
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Thomas Berry

3. (b) Social Security Number

Don't know

4. Sex

male

5. Color or race

Col.

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

Don't know of any

7. Birth date of

deceased (mo., day, yr.)

Some where above
March 27 1917

8. AGE:

Years

29

Months

6

Days

4

If less than one day

hrs.

4

min.

9. Birthplace

Nassau Bahamas, B.W.I.
(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

Farm

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Address

17. Burial Date thereof Sept 29 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Hanston

Location

Salisbury and

18. Funeral director

James Stewart

Address

Salisbury and19. 9/29
(Date filed by registrar)19. 4619. 4619. 4619. 46

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 46 1946, at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 18 46 1946 to Sept 27 46 1946and that I last saw him alive on Sept 26 46 1946

Immediate cause of death

Peptic Ulcer

DURATION

3-4 months

Due to

Due to

Other conditions

Perforation of Peptic Stomach
Ulcer with internal haemorrhage
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Ellen G. M. Wassman

M. D. or other

Address Princess Anne 1002 Date signed 9.28.46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 8 1945

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 750

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:

County... Somerset
 City or town... Princess Anne and Route 2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 31 Years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Somerset
 City or town... Princess Anne
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Angella Nutter Handy

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Col Married

6. (b) Name of husband Ray Handy

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age years

1915
 8. AGE: Years Months Days If less than one day
31 hrs. min.

9. Birthplace Somerset Co., Md.
(Town, county, and state)10. Usual occupation Domestic Worker11. Industry or business House work12. Name John Nutter13. Birthplace Somerset County Md14. Maiden name Laura Williams15. Birthplace Wicomico Co., Md.16. Informant Edw JonesAddress Princess Anne Route 2, Md17. Burial Date thereof Sept. 7 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Calvi Road CemeteryLocation Mt. Vernon, Md.18. Funeral director Edw JonesAddress Rt. 2, Princess Anne Md19. 9/7 46 R. H. Johnson
(Date rec'd by registrar) (year) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3rd 1946, at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1st 1945, to Sept 3rd 1946
 and that I last saw him alive on Sept 3rd 1946

Immediate cause of death

Acute Coriatic Asthma DURATION 3 months

Due to

Due to

Other conditions Bronchial Asthma 3 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edw Jones M. D. or otherAddress Princess Anne Md Date signed 9.7.46

UNITED STATES DEPARTMENT OF HEALTH

HEADQUARTERS

RECEIVED
SEP 10 1946
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

092882 65

1. PLACE OF DEATH:

County..... Dominican

City or town..... San Rafael

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 yrs

Hospital, institution, or street address where death occurred:

.....

.....

.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....Maryland..... County.....Somerset.....

City or town.....Charles C.....
(If outside city or town limits, write RURAL and give nearest town)

Street No.....Charlotte Ave.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....None.....

3. (a) FULL NAME
Daniel W. Harrison

3. (b) Social Security Number
None.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife the late Frances S.

7. Birth date of deceased (mo., day, yr.) *15 Feb 15 1862*

8. AGE:	Years	Months	Days	if less than one day
	84	7	8 hrs. mi.

9. Birthplace..... Poplar Island Md.
(Town, county, and state)

10. Usual occupation.....Retired Waterman.....

11. Industry or business Self

12. Name William F. Harrison

R FA 13. Birthplace

14. Maiden name..... Sally H. Harrison

MI 15. Birthplace ✓ USA

16. Informant Julius Ball

Address Longfield MD

(Burial, cremation, or removal. Which?) Date thereof: 12-1-68 (month) (day) (year)

Cemetery or crematory Graveside

Location Donfield mic

18. Funeral director.....

Address (Crossed out) 1000

19. 2/27/69 (Date rec'd by registrar) T. G. Callahan, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1946 at 10³⁰

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2, 1946, to Sept 19, 46, and that I last saw him alive on September 19, 46.

Immediate cause of death	DURATION
Coronary occlusion	

General Arterio Sclerosis

Due to Hypertension

Other conditions: None

..... 14 months - alive
(Include pregnancy within 3 months of death)

Major findings of operations.....Date of op.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. **VIOLENCE:** If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)	
Means of injury	Injured at work?
.....

Исходные данные: 11.5

23. SIGNATURE [Signature] M.D. or other _____

Address Brushy Mt Date signed 9-24-46

RECEIVED

OCT 4 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 00289261

1. PLACE OF DEATH: Somerset
County.....
City or town..... Rural, Kingston
(If outside city or town limits, write RURAL and give nearest town)
Lifetime
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Somerset
City or town..... Rural, Kingston
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
PETER OTIS HUDSON

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
Mattie Jones Hudson
8.(b) Name of husband or wife.....
6.(c) If alive, give age 68 years
7. Birth date of deceased (mo., day, yr.) April 30, 1870
8. AGE: Years 76 Months 4 Days 15 If less than one day hrs. min.

9. Birthplace..... Kingston-Somerset-Md.
(Town, county, and state)
Farmer-Canner
10. Usual occupation.....
Farming
11. Industry or business
12. Name..... Peter Hudson
13. Birthplace..... Somerset Co., Md.
14. Maiden name..... Mary Landing
15. Birthplace..... Somerset Co., Md.

16. Informant..... Manuel Hudson
Address..... Kingston, Md.
Burial Date thereof Sept 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Rehobeth Presbyterian Cem
Rural, Marion, Md.
Location.....
H. Harvey Bradshaw
18. Funeral director.....
Address..... Crisfield, Md.

19. Date rec'd by registrar Sept 21, 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15, 1946, at 240 P
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 1, 1946, to Sept 15, 1946
and that I last saw him alive on Sept 14, 1946

Immediate cause of death..... Acute Del of Heart
Due to..... Chronic Hypertension
Chronic Dist. reg. vels.
Due to.....
Other conditions..... Bristle Asphyxia?
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE..... Surgeon C. Crullman M.D.
M. D. or other
Address..... Marion Co. Mo. Date signed Sept 16, 1946

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SEP 24 1916
BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No. 09290 260

1. PLACE OF DEATH:

County Somerset
 City or town Princess Anne Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Jennie Ingersoll
 4. Sex Female 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 1, 1874

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

72

hrs.

min.

9. Birthplace

Princess Anne, Somerset, Md.
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

MOTHER FATHER

12. Name

James Smullans

13. Birthplace

Princess Anne Md.

14. Maiden name

Unknown

15. Birthplace

16. Informant

Morris Ward

Address

Princess Anne, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Sept 14, 1946
(month) (day) (year)

Cemetery or crematory

Allen Cemetery

Location

Allen, Md.

18. Funeral director

Charles Dashiell

Address

Princess Anne, Md.

19.

(Date rec'd by registrar)

9/1346R. H. Johnson
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 12, 1946 at 19 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19, to 19

and that I last saw him

alive on

19

Immediate cause of death

DURATION

Chronic heart disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injured at work?

Means of injury

23. SIGNATURE

Henry W. Safford M.D.

M. D. or other

Address

Princess Anne, Md.

Date signed

9/13/46

RECEIVED
SEP 14 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 330

CERTIFICATE OF DEATH

09291

Reg. Dist. No. 265

1. PLACE OF DEATH:
 County Somerset
 City or town Bayfield R.T.D. 2.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State MD County Somerset
 City or town Bayfield R.T.D. 2.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
Malissia E Johnson

3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife William Johnson

7. Birth date of deceased (mo., day, yr.) Aug 9 - 1870 6. (c) If alive, give age years

8. AGE: Years 76 Months 3 Days 28 If less than one day hrs. min.

9. Birthplace Bayfield Somerset Co MD
 (Town, county, and state)

10. Usual occupation House work

11. Industry or business

12. Name John Sampel

13. Birthplace Accomack Co Va

14. Maiden name Rachel Winters

15. Birthplace Orloee Md

16. Informant Rachel Jones

Address Bayfield Md R.T.D. 2.

17. Burial Date thereof Sept 9 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hopewell

Location Bayfield Md R.T.D. 2

18. Funeral director Chas H Ward

Address Morgans Md

19. Sept 7 1946 Registrar

(Date registered) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1946 at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 1946 to Sept 6 1946

and that I last saw him alive on Sept 7 1946

Immediate cause of death Cerebral Hemorrhage DURATION

Arteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE S. M. Payton M.D. M. D. or other

Address Crisfield, Md Date signed Sept 7 1946

RECEIVED

OCT 4 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

09292 261
Reg. Dist. No.

1. PLACE OF DEATH:

County Sonoma
City or town Marion Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD. County Sonoma
City or town Marion Station
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Richard Lloyd

3. (b) Social Security Number

✓

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Marion C. Lloyd
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) June 5, 1888.

8. AGE: Years 66 Months 3 Days 12 If less than one day
hrs. min.

9. Birthplace Newton, N.H.
(Town, county, and state)

10. Usual occupation Miner

11. Industry or business

12. Name Richard Lloyd

13. Birthplace N.H.

14. Maiden name Not known

15. Birthplace N.H.

16. Informant Mrs. Richard Lloyd

Address Marion Station, Md. R.R. 3

17. Burial Date thereof 9/19/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Paul's Episcopal Church

Location Marion Station, Md.

18. Funeral director De Kilde & Son Co.

Address Schickau, Md.

19. Sept 21, 46 Registrar Long J. Nelson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 19 46 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 19 46 to Sept 17 19 46 and that I last saw him alive on Sept 17 19 46

Immediate cause of death

Acute Die 7. Heart

Due to General arterio Sclerosis

Due to Chronic Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Long C. Poultham M.D.

Address Sept. 18 Marion St. Date signed Sept 18, 46

RECEIVED
SEP 24 1946
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

09293 260
Reg. Dist. No.

1. PLACE OF DEATH:

County... Somerset
City or town... Oriole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Md County... Somerset
City or town... Oriole
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Julia E Maddox

3. (b) Social Security Number

4. Sex Fem 5. Color or race Cal 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Omar Maddox
6.(c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) Feb 21, 1889
8. AGE: Years 57 Months 6 Days 27 If less than one day hrs. min.

9. Birthplace Oriole Somerset Md
(Town, county, and state)
10. Usual occupation House work

11. Industry or business

12. Name Ancha Wastes
13. Birthplace Oriole Md.
14. Maiden name Julia Jones
15. Birthplace Venton Md

16. Informant Omar Maddox
Address Oriole Md.

17. Burial Date thereof Sep 22-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oriole Md
Location Oriole Md

18. Funeral director Chas H Ward
Address Marion Md

19. Sept 21, 1946 R. J. Johnson M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1946 at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1946 to Sept 20 1946
and that I last saw him alive on Sept 19 1946

Immediate cause of death Coronary thrombosis

Due to coronary thrombosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Matus M.D.
Address Princess Anne Date signed 9/21/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 24 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-2

CERTIFICATE OF DEATH

09294

Reg. Dist. No. 265

1. PLACE OF DEATH: Somerset
County.....
City or town..... Crisfield
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Somerset
City or town..... Crisfield
(If outside city or town limits, write RURAL and give nearest town)
Street No..... Paper Street
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Martha Miles

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife.....
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) March 21, 1889
8. AGE: Years 57 Months 5 Days 12 If less than one day
..... hrs. min.

9. Birthplace Crisfield-Somerset-Maryland
(Town, county, and state)
10. Usual occupation Seafood Worker
11. Industry or business Crabs & Oysters
FATHER 12. Name Isaac William Miles
13. Birthplace Somerset County, Md.
MOTHER 14. Maiden name Amanda Blake
15. Birthplace Crisfield, Md.
16. Informant Blanche Wilson
Address Crisfield, Md.
17. Burial Date thereof Sept 26, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Union Asbury Cemetery
Rural, Crisfield, Md.
Locallon H. Harvey Bradshaw
18. Funeral director
Address Crisfield, Md.
19. 9/25/46 6 E. Collins M-19
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1946 at 10:15 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1946 to Sept. 23 1946
and that I last saw her alive on Sept. 23 1946

Immediate cause of death
Chronic myocarditis 9 mos.
Chronic nephritis 9 mos.

Due to.....
Due to.....
Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S. M. Peyton M. J.
M. D. or other
Address Crisfield, Md. Date signed Sept 25, 1946

RECEIVED
OCT 4 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 168

CERTIFICATE OF DEATH

09295

Reg. Dist. No. 360

1. PLACE OF DEATH:

County SomersetCity or town Near Princess Anne Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clarence Mitchell

3. (b) Social Security Number

4. Sex Male 5. Color or race Col 6. (a) Single, married, widowed, or divorced Not known

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Not known 8. (c) If alive, give age years8. AGE: 68(?) Years Months Days If less than one day hrs. min.9. Birthplace
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Not known13. Birthplace Not known14. Maiden name Not known

15. Birthplace

16. Informant Elijah SavageAddress Princess Anne Md17. Burial Date thereof 9-30-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Alma's HouseLocation Not known18. Funeral director William H. JamesAddress Princess Anne Md19. Sept. 30, 1946 R. L. Johnson, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 19 46, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death Fractured skull DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. UNDERLINE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 9/26/46Where did injury occur? Near Princess Anne Somerset Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) FarmMeans of injury Struck by tree Injured at work? no23. SIGNATURE Henry M. Southford M.D. or otherAddress Princess Anne Md Date signed 9/27/46

RECEIVED
OCT 4 1946
BUREAU OF
B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 172

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:		Somerset	
County.....		Crisfield	
City or town.....		(If outside city or town limits, write RURAL and give nearest town)	
How long in above place of death?		3 months	
Hospital, institution, or street address where death occurred:			
How long in hospital or institution?			
3. (a) FULL NAME		Rudolph Owens	
3. (b) Social Security Number			
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
Male	Colored	Single	
B. (b) Name of husband or wife.....			
7. Birth date of deceased (mo., day, yr.)		6. (c) If alive, give age..... years	
March 27, 1931			
8. AGE:	Years	Months	Days
	15	5	26
If less than one day..... hrs. min.			
9. Birthplace..... Herrellville-Herrellville-M.C.			
(Town, county, and state)			
10. Usual occupation..... Seafood Worker			
11. Industry or business..... Oyster			
12. Name..... John Thomas Owens			
13. Birthplace..... Herrellville Co. N. C.			
14. Maiden name..... Mary Artis			
15. Birthplace..... Herrellville Co. N. C.			
16. Informant..... Mary Artis			
Address..... Hallwood, Virginia			
Removal - Burial..... Sept 26, 1946			
(Burial, cremation, or removal. Which?) (month) (day) (year)			
Cemetery or crematory..... Private Cemetery			
Location..... Hallwood, Virginia			
18. Funeral director..... H. Harry Bowers			
Address..... Crisfield, Md.			
9/24/46			
19. (Date rec'd by registrar)			
20. DATE OF DEATH..... Sept 23, 1946			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... to.....			
and that I last saw him..... alive on.....			
Immediate cause of death..... Accidental			
Due to..... Drowned,			
fell in water from Boat			
Other conditions.....			
(Include pregnancy within 3 months of death)			
Major findings of operations.....			
Date of op.....			
Autopsy results.....			
PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following:			
Accident..... Date of..... 9. 23. 45			
Where did injury occur..... Crisfield, Somerset Md			
(City or town) (County) (State)			
Injured at home, farm, industry, public place (where?)..... fell in water			
Injury..... in Harbor, Crisfield, Md			
Drowned			
23. SIGNATURE..... W. H. Bowers M.D.			
Address..... Crisfield Md			
Date signed..... 9. 24. 46			

RECEIVED

OCT 4 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-E

09297

CERTIFICATE OF DEATH

Reg. Dist. No.

268

1. PLACE OF DEATH:

County... Somerset
 City or town... Danvers Quarters Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifetimeHospital, institution, or street address where death occurred: —How long in hospital or institution? —

3. (a) FULL NAME

Daniel I. Shores

3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife —7. Birth date of deceased (mo., day, yr.) April 30th 18818. AGE: Years 65 Months — Days — If less than one day — hrs. — min. —9. Birthplace Danvers Quarters Md
(Town, county, and state)10. Usual occupation Oysterman11. Industry or business Waterman12. Name Emory Shores13. Birthplace Danvers Quarters Md14. Maiden name Margaret White15. Birthplace Danvers Quarters Md16. Informant Elmer C. ShoresAddress Danvers Quarters Md17. Burial — Date thereof Sept 18-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Danvers Quarters M.E.Location Danvers Quarters Md18. Funeral director H. H. WhiteAddress Deals Island Md19. Sept 19th 46 Rosa White
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County SomersetCity or town Danvers Quarters
(If outside city or town limits, write RURAL and give nearest town)Street No. —
(If rural, give LOCATION)2. (a) If veteran, name war —

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16th 1946 at 9:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19— to — 19—and that I last saw him — alive on — 19—Immediate cause of death Chronic NephritisDue to —Due to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE — M. D. or otherAddress — Date signed 9/19-46

RECEIVED

SEP 24 1946

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 2690

1. PLACE OF DEATH:

County Somerset
City or town Bridge Champ
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Somerset
City or town Bridge Champ
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Anna Shores

3. (b) Social Security Number

none4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Charles Shores6. (c) If alive, give age 76 years7. Birth date of deceased (mo., day, yr.) Oct 24, 18708. AGE: Years 76 Months 1 Days 27 If less than one day _____ hrs. _____ min.9. Birthplace Bridge, Somerset, Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Isaac J. Windsor13. Birthplace Bridge Md.14. Maiden name Lucan Ford15. Birthplace Somerset County16. Informant Charles ShoresAddress Champ Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 22, 1946
(month) (day) (year)Cemetery or crematory Burial order of MechanicsLocation Bridge Md.18. Funeral director Dale OrshullAddress Princess Anne, Md.19. Dec 22 19 46 Wm S. Brumitt
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 19 46 at 3:00 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 10 19 46 to Dec 19 19 46and that I last saw him alive on Dec 19 19 46Immediate cause of death Cerebral Hemorrhage DURATION 20 hoursDue to Cerebral Arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank W. W. W. M. D. or otherAddress Princess Anne Date signed 12/20

MARGIN RESERVED FOR BINDING

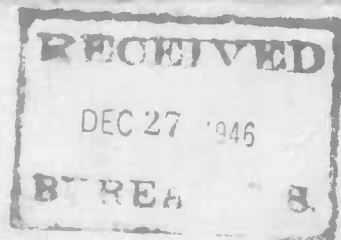
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VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9449

2690



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B1-0

CERTIFICATE OF DEATH

09298

★ Reg. Dist. No. 261

1. PLACE OF DEATH:

County... Somerset
 City or town... Marion
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Somerset
 City or town... Marion
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... world war 1 ★

3. (a) FULL NAME

Caleb E Sterling

3. (b) Social Security Number

213-18-5946

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Col married

6. (b) Name of husband or wife Jennie Sterling

6. (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1891

8. AGE: Years 55 Months 0 Days 28 hrs. min.

9. Birthplace Marion Somerset Co Md
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business

12. Name Caleb Sterling

13. Birthplace Marion Co Somerset Co.,

14. Maiden name Jennie Handy

15. Birthplace Marion Co Somerset Co.,

16. Informant Annie Sterling

Address Marion Sta Somerset Co Md

17. Burial Date thereof Sept 29, 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Branch

Location Marion Sta. Md.

18. Funeral director Chas H Ward

Address Marion Sta Md

19. Sept 28, 1946
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1946 5:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Sept 26 1946

and that I last saw him alive on Sept 20 1946

Immediate cause of death

Cerebral Dementia and

Nephritis

Due to Chronic Nephritis

Due to Chronic Nephritis

Other conditions General Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Guy C. Quillen M.D.

Address Marion Sta Md Date signed Sept 28, 1946

ARTESIAN LIFT

NO CONTENT

RECEIVED
OCT 1 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-7

CERTIFICATE OF DEATH

 09299265
 Reg. Dist. No.

1. PLACE OF DEATH: County..... <u>Somerset</u> City or town..... <u>Crisfield</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>Lifetime</u> Hospital, institution, or street address where death occurred: <u>7th Street</u> How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Somerset</u> City or town..... <u>Crisfield</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>7th Street</u> (If rural, give LOCATION) 2.(a) if veteran, name war.....											
3. (a) FULL NAME <u>JOHN WILLIAM NELSON TAWES</u>				3. (b) Social Security Number											
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>		MEDICAL CERTIFICATION									
6. (b) Name of husband or wife <u>Hettie Dize</u>		6. (c) If alive, give age <u>71</u> years		20. DATE OF DEATH <u>Sept 30</u> 19 <u>1946</u> at <u>7</u> P. M.		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>July 1st</u> 19 <u>1946</u> to <u>Sept 30</u> 19 <u>1946</u> and that I last saw him alive on <u>Sept 30</u> 19 <u>1946</u> .									
7. Birth date of deceased (mo., day, yr.) <u>November 26, 1860</u>		8. AGE: <table border="1"> <tr> <td>Years</td> <td>Months</td> <td>Days</td> <td>If less than one day</td> </tr> <tr> <td><u>85</u></td> <td><u>10</u></td> <td><u>4</u></td> <td>..... hrs. min.</td> </tr> </table>		Years	Months	Days	If less than one day	<u>85</u>	<u>10</u>	<u>4</u> hrs. min.	Immediate cause of death <u>as a result of heart</u>		DURATION <u>1 hour</u>	
Years	Months	Days	If less than one day												
<u>85</u>	<u>10</u>	<u>4</u> hrs. min.												
9. Birthplace <u>Crisfield-Somerset-Maryland</u> (Town, county, and state)				Due to		Due to									
10. Usual occupation <u>Seafood industry</u>				Due to		Other conditions <u>Cancer of rectum</u> (Include pregnancy within 8 months of death)									
11. Industry or business <u>Packer</u>				Major findings of operations		Date of op.									
12. Name <u>Edward Tawes</u>		13. Birthplace <u>Crisfield, Maryland</u>		Antopsy results		PHYSICIAN: Please underline the cause to which death should be charged statistically.									
14. Maiden name <u>Grace Lawson</u>		15. Birthplace <u>Crisfield, Maryland</u>		22. VIOLENCE: If death was due to external causes, fill in the following;		Accident, suicide, or homicide Date of									
16. Informant <u>Edward Tawes</u> Address <u>Crisfield, Maryland</u>				Where did injury occur? (City or town) (County) (State)		Injured at home, farm, industry, public place (where?)									
17. (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>Oct. 3, 1946</u> (month) (day) (year) Cemetery or crematory <u>Crisfield Cemetery</u> Location <u>Crisfield, Maryland</u>				Means of Injury		Injured at work?									
18. Funeral director <u>H. Harvey Bradshaw</u> Address <u>Crisfield, Maryland</u>				23. SIGNATURE <u>to E. Bradshaw</u> M. D. or other		Date signed <u>Oct 2, 1946</u>									
19. (Date rec'd by registrar) <u>Oct 2, 1946</u>				Registrar <u>E. Bradshaw</u>		Address									

RECEIVED

OCT 4 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-2

CERTIFICATE OF DEATH

Reg. Dist. No.

09300

265

1. PLACE OF DEATH:

County..... Somerset
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 34 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Somerset
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Wards Crossing
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Alberta Ruth Taylor

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widowed
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Nov. 17, 1884
 8. AGE: Years..... 61 Months..... 10 Days..... 11 If less than one day..... hrs. min.

9. Birthplace..... Perryhawkin-Somerset Co.
 (Town, county, and state)

10. Usual occupation..... House wife

11. Industry or business.....

FATHER 12. Name..... William Carter

13. Birthplace..... Somerset County, Md.

MOTHER 14. Maiden name..... Mary Adams

15. Birthplace..... Westover, Md.

16. Informant..... Harry Taylor

Address..... Philadelphia, Penna.

17. Burial, cremation, or removal. Which?..... Burial Date thereof..... Oct. 1, 1946
 (month) (day) (year)

Cemetery or crematory..... Mariners Cemetery

Location..... Crisfield, Maryland

18. Funeral director..... H. Harvey Bradshaw

Address..... Crisfield, Maryland

19. 10/1/46 19. E. E. Collins M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 28 1946, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 21 1946 to Sept 28 1946

and that I last saw him alive on Sept. 27 1946

Immediate cause of death.....

Chronic myocarditis

Hypertension

Md.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

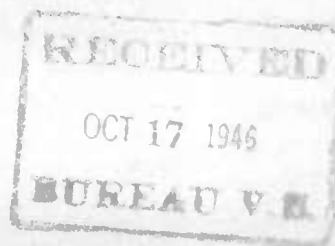
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... S. M. Peyton M.D.

Address..... Crisfield, Md. Date signed..... Oct 1, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 09301-460

1. PLACE OF DEATH:

County SomersetCity or town Chance
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Chance
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Hester League

3. (b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female col. widowed

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 5 18758. AGE: Years Months Days If less than one day
71 _____ hrs. _____ min.9. Birthplace Chance, Somerset, Md.
(Town, county, and state)10. Usual occupation housewife

11. Industry or business _____

12. Name Nathan Reed13. Birthplace Chance, Md.14. Maiden name Sarah Reed15. Birthplace Chance, Md.16. Informant J. E. ThomasAddress Aacomac, Virginia17. Burial Date thereof Sept. 15, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Methodist CemeteryLocation Chance, Maryland18. Funeral director J. E. ThomasAddress Aacomac, Virginia19. Sept. 13, 46 19 46
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13th 19 46, at 9:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 15th 19 42, to Sept 13th 19 46and that I last saw him alive on Sept 10th 19 46

Immediate cause of death _____ DURATION

Cerebral Hemorrhage 5 hours

Due to _____

Due to _____

Other conditions Hypertension 4 years

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE George G. Maysman M. D. or otherAddress Pine Anne, Md. Date signed 9.13.46

WESTLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF MICHIGAN

DEATH

INVESTIGATION

RECEIVED
SEP 17 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:

County.....Somerset
 City or town.....Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....17 years
 Hospital, institution, or street address where death occurred:
136 South Puorth Street
 How long in hospital or institution?.....47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....Maryland County.....Somerset
 City or town.....Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....136 South Puorth Street
 (If rural, give LOCATION) 47
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Albert Wilkins

3. (b) Social Security Number

4. Sex.....Male 5. Color or race.....Colored 6.(a) Single, married, widowed, or divorced.....Married
 6.(b) Name of husband or wife.....Jeanette Wilkins

6.(c) If alive, give age.....39 years

7. Birth date of deceased (mo., day, yr.).....July 16, 1904

8. AGE: Years.....42 Months.....1 Days.....23 If less than one day.....hrs.min.

9. Birthplace.....Eastville-North Hampton-Va
 (Town, county, and state)

10. Usual occupation.....Sea Food Laborer

11. Industry or business.....Oyster Packing House

12. Name.....Alfred Wilkins

13. Birthplace.....North Hampton County, Va.

14. Maiden name.....Sarah Bailey

15. Birthplace.....North Hampton County, Va.

16. Informant.....Willie Wilkins

Address.....Crisfield, Maryland

17. Burial Date thereof.....Sept. 12 1946

(Burial, cremation, or removal. Which?) (Month) (day) (year)

Cemetery or crematory.....Wayman Cemetery

Location.....Marion, Maryland

18. Funeral director.....H. Harvey Bradshaw

Address.....Crisfield, Maryland

19. Sept 16 1946 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....September 9 1946 at.....1:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from.....never attended

and that I last saw him.....alive on

Immediate cause of death.....Organic Heart DURATION.....

Due to.....Acute Cardiac

Due to.....Exhaustion

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results.....no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....natural cause

Where did injury occur?.....(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....no

Means of injury.....Injured at work?

23. SIGNATURE.....Wm. H. Canbourn M.D. or other

Address.....Crisfield, Md. Date signed.....9.10.46

MASSACHUSETTS DEPARTMENT OF HEALTH

1001 IN CHARGE OF DEATH

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, MASSACHUSETTS

1001 IN CHARGE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

RECEIVED

OCT 4 1916

BUREAU V B

MASSACHUSETTS DEPARTMENT OF HEALTH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

CERTIFICATE OF DEATH

Reg. Dist. No. 268

1. PLACE OF DEATH:

County SomersetCity or town Chance Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Chance Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Layfiat Whitlock

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Oliver Whitlock6. (c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) October 2, 18698. AGE: Years 76 Months 11 Days 30 It less than one day _____ hrs. _____ min.9. Birthplace Chance, Somerset, Md.
(Town, county, and state)10. Usual occupation Widower

11. Industry or business

12. Name James Whitlock13. Birthplace Chance Md.14. Maiden name Unknown

15. Birthplace _____

16. Informant Mrs. James WhitlockAddress Chance Md.17. Burial Date thereof Oct 2, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ChanceLocation Chance Md.18. Funeral director State DashiellAddress Princess Anne Md.19. Oct 2, 1946 Rosa Welton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 19 46 at 11:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 19 46 to Oct 29 19 46and that I last saw him alive on Sept 29 19 _____Immediate cause of death Cerebral ThrombosisDURATION 1 wkDue to generalized arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frankie Matis MD

M. D. or other

Address Princess Anne Date signed 10/1/46

RECEIVED
OCT 15 1946
BUREAU V. N.